OUTCOME

Agency Name: _____ Applicant Name: _____

Provider-Assessor # ☐☐☐☐☐☐☐☐–☐☐☐ Social Security # ☐☐☐–☐☐–☐☐☐☐

Assessment Date: ☐☐–☐☐–☐☐☐☐ MaineCare # ☐☐☐☐☐☐☐☐

SECTION T. ASSESSMENT TYPE/VERSION

1.	TYPE	**1.** Initial (original) **2.** Reassessment	☐
2.	VERSION	**1.** Original **3.** Conversion **5.** Reinstated **2.** Revision **4.** Pending appeal **6.** Update	☐
3.	ASSESSMENT/ COMMUNITY PROGRAM ELIGIBILITY	**1. Assessment Requested** from 6B — *Check only one.* **2. Community Program Eligibility** from scoring pages — *Check all that apply.*	

1. ASMNT REQUESTED	2. PROGRAM		1. ASMNT REQUESTED	2. PROGRAM ELIGIBILITY	
		1. Long Term Care Advisory			16. 20-day copay to NF MaineCare
		2. Adult Day Care Program			17. 30-day Community MaineCare NF
		3. BEAS Home Maker			18. Advisory to MaineCare Update
		4. MaineCare Day Health			19. Adv. Medicare to Private Pay NF
		5. Consumer Directed PCA			20. Continuing Stay Review
		6. Home Based Care			21. Extraordinary Circumstances to NF
		7. Phys. Dis. HCB			22. Katie Beckett
		8. Elderly HCB			23. Level IV - NF PDN
		9. Adult w/ Disability HCB			24. Congregate Housing
		10. PDN - Level I, II, III			25. TBI
		11. Adult Family Care Home			26. MaineCare Home Health
		12. Level V - Extended PDN			27. PDN Medication - Level VI
		13. NF Assessment			28. PDN Venipuncture Only - Level VII
		14. 20-day Medicare/MaineCare			29. Cons. Directed HBC
		15. Medicare to MaineCare			

4.	CONSUMER CHOICE *(Choose one.)*	**1.** Community Options **3.** Advisory only **5.** NF **2.** Residential Care **4.** No choice	☐
5.	ADVISORY PLAN	Program referrals given to consumer as an advisory 0 - No 1 - Yes Advisory medical eligibility determination is valid for 30 days. Valid from: _____ to _____ ☐ 0-NA	☐

SECTION U. NF MEDICAL ELIGIBILITY

1. Based on this assessment, the consumer appears to be medically eligible for NF level of care. 0 - No 1 - Yes ☐
   Complete regardless of consumer choice.

SECTION V. AWAITING PLACEMENT

1. a. FOR: **0.** NA **1.** NF **2.** MaineCare HCB - Elderly, AD **3.** PDN ☐
   b. AT: **0.** NA **3.** Home ☐
   1. NF **4.** Out-of-state
   2. Hospital (*specify*) _____
   c. Valid eligibility: from _____ to _____ ☐ 0 - NA

SECTION W. NF/HOSP/HHA DATES

1. Acute care denial date: _____ ☐ 0 - NA
2. First Non-SNF Date: _____ ☐ 0 - NA
3. Last day private pay: _____ ☐ 0 - NA
4. Late notification date 0 - No 1 - Yes ☐
5. Bed hold expired 0 - No 1 - Yes ☐
6. Home Health end date: _____ ☐ 0 - NA

SECTION X. NF FACILITY

1. a. Will be entering a NF 0 - No 1 - Yes ☐
   b. Is currently in a NF 0 - No 1 - Yes ☐
   c. NF Name: _____ ☐ 0 - NA
   d. Eligibility start date: _____ ☐ 0 - NA
   e. Reassess date: _____ ☐ 0 - NA
   f. End date: _____ ☐ 0 - NA
   (30-day MaineCare only)
   g. Admission date: _____ ☐ 0 - NA

SECTION Y. LATE SUBMISSION

1a. Reason: **1b.** To: ☐ 0 - NA

☐ a. Provider not chosen ☐ a. BMS ☐ c. BEAS
☐ b. Financial pending ☐ b. HCCA ☐ d. Other
☐ c. Consumer request

SECTION Z. COMMUNITY BENEFITS

FUNDING SOURCE (from Care Plan)	PROVIDER	ELIGIBILITY START DATE	REASSESS DATE	WAIT LIST
				☐
				☐
				☐

RESIDENTIAL CARE REFERRAL

				☐

BENEFITS DENIED

FUNDING SOURCE	ACTION	REASON	10-DAY	DISCHARGE DATE	DISCHARGE TO
			☐		
			☐		
			☐		

NOTICE DATES

Date of denial: _____
☐ 10-day Date: _____
☐ 60-day Notice: _____
☐ Appeal
Reinstate 0 - No 1 - Yes ☐
Date: _____

SIGNATURE

Assessment Date | Assessment Version | Assessor Signature | Signature Date

FOR OFFICE USE ONLY BEAS/BFI

☐ APRC

BEAS request date _____ to _____

BFI approved begin date _____ to _____